Iowa Department of Human Services

REQUEST TO END AN AUTHORIZATION

Name of Client	Date of Request	
Mailing Address – Street or P.O. Box	Social Security Number, Patient number, or State ID	
City, State, and Zip Code	Phone Number	Birth Date

Check all of the programs that apply: ☐ Medicaid ☐ ***hawk-i*** ☐ Facility

To be completed by the client or the client's personal representative

I request that the authorization I signed to release health care information to

(name of person or organization) _____

dated _____ be stopped.

I understand that this request to end the authorization cannot apply to any action the Department has already taken on the authorization before this date.

Client or Personal Representative's Signature	Date